Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 02/02/01?

   b. The request was received on 01/31/02.

II. EXHIBITS

1. Requestor, Exhibit 1:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 03/07/02
   b. HCFA 1450s
   c. EOB
   d. EOBs from other Carriers
   e. Extended list of reimbursements from other carriers
   f. Medical Records
   g. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 03/27/02
   b. HCFA 1450s
   c. Carrier’s methodology
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. The Reviewer is unable to determine by the dispute packet if this response is timely or not. Therefore, Medical Dispute will write the decision as timely.

III. PARTIES' POSITIONS

1. Requestor:

> "The most common CPT codes utilized by the Provider involve treatment, services, and supplies that do not have a maximum allowable reimbursement (MAR). Therefore, the Provider made an extensive review of payments and reimbursements made by various Carriers throughout the geographical area of Texas for treatment, services and supplies utilized for both work-related and non-work related injuries. As a result of that review, the Provider was able to determine the usual amounts reimbursed by Carriers for treatment, services, and supplies from the Provider for both work-related and non-work related treatment in the state of Texas at their facility." Additional reimbursement is sought in the amount of $4,087.21 for date of service 02/21/01.

2. Respondent:

> "It is the ... position that a) the requestor failed to produce any credible evidence that its billing for the disputed procedures is fair and reasonable; b) the requestor failed to prove its usual and customary fees for the service in dispute is fair and reasonable are consistent with Section 413.011(b); c) the ...payment is consistent with fair and reasonable criteria established in Section 413.011(b) of the Texas Labor Code; and d) Medicare fair and reasonable reimbursement for similar or same services is below the ..." The carrier denies additional reimbursement of $4,087.21 for date of service 02/02/01.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible is 02/02/01.

2. The Provider billed the Carrier $9,905.31 for the date of service 02/02/01.

3. The Carrier paid $1,231.60 for the disputed date of service 02/02/01.

4. The Provider is seeking additional payment in the amount of $4,087.21 per the TWCC-60.

5. The services provided by the Requestor include such items as anesthesia and lab services, pharmaceutical products, medical and surgical supplies, sterile supplies and EKG.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. The provider has submitted additional reimbursement data (EOBs from various carriers) for similar services to patients of an equivalent standard of living in their geographical area. This information does provide some evidence of a fair and reasonable charge.

However, the carrier has submitted documentation asserting that they have in fact paid a fair and reasonable reimbursement. Respondent has submitted an explanation of their methodology. Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and /or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

"develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;explain and document the method it used to calculate the rate of pay, and apply this method consistently;reference its method in the claim file; and explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The Carrier has explained their methodology as follows:

The Carrier's methodology incorporates information from:

1) U.S. Department of Health and Human Services. Health Care Financing Administration. "Ambulatory Surgical Center 1994 Medicare Payment Rate Survey" http://www.hcfa.gov/medicare/ascread.htm, August 13, 1998.
1) U.S. Department of Health and Human Services, Health Care Financing Administration, "Medicare Program: Update of Ambulatory Surgical Center Payment Rates Effective for Services on or after October 1, 1997" (Notices) Federal Register. 63FR19FE98 8462-8465.

The Carrier indicates that Medicare classifies surgical procedures into 8 groups. All CPT Codes within the same grouping are paid at the same rate (group rate). That reimbursement allowed by Medicare is then multiplied by 20%. This is the copay amount under Medicare that the patient pays and which is not allowed by Texas Workers' Compensation Act. The group rate and the copay amount are added together to determine the total payment.

The Carrier notes that regional and geographic differences are taken into account by Medicare. However, the Fund believes that by taking the group rate and adding in the copay amount, that its reimbursement is higher than Medicare's rate of reimbursement.

Exhibit 2 is a copy of the ASC groups as indicated by the Federal Register, 12/14/93. The Carrier has submitted additional information to further support its methodology. Exhibit 3 is a List of Percentage Payments by Texas WC Insurances.

Due to the fact that there is no current fee guideline for ASCs, the Medical review Division has to determine, based on the parties' submission of information, who has provided the more persuasive evidence. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable.

Therefore, **no** further reimbursement is recommended.

The above Findings and Decision are hereby issued this 16th day of April 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division